

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2675

CERTIFICATE OF DEATH

Reg. Dist. No.

02587

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>E.</u> Last <u>BRUNO</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISH DOCK.</u>	
11. BIRTHPLACE (State or foreign country) <u>OLD FORD PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL BRUNO</u>		14. MOTHER'S MAIDEN NAME <u>ANNA TERRANA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give year or dates of service) <u>1942-1946</u>		16. SOCIAL SECURITY NO. <u>63-18-061</u>	
17. INFORMANT <u>MRS. SAMUEL BRUNO</u>		Address <u>BERLIN MD R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Capsuomycin Hemorrhage</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Metastasis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>3 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus, med.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>Feb 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herma H. Kuehn</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin Md</u> DATE SIGNED <u>2/10/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burboze</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Al. Heath</u>
		DATE <u>FEB 13 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. CH. 111

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
---	--	--

FEB 13 1958

BUREAU V. 3

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2606 CERTIFICATE OF DEATH

Reg. Dist. 42588

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural #2 Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural #2 Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willie</u> <u>Wale</u>		4. DATE OF DEATH Month Day Year <u>Feb</u> <u>2</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1891</u>
9. AGE (In years last birthday) <u>66 10 25</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Arnetta Selby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Jessie Wale, Snow Hill, Md. RFD #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPER TENSIVE CARDIOVASCULAR DISEASE 10 YRS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> 19... to <u>2/2/58</u> 19..., that I last saw the deceased alive on <u>1-31-58</u> 19..., and that death occurred at <u>1 A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. LaMar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>104 Bay Street</u> <u>2-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. LaMar, M.D.</u>		<u>Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 4/58</u>	<u>Friendship</u>	<u>Snow Hill Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Dennis, Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Maryland	
7. DATE OF DEATH Feb 3 1933		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. PREVIOUS ILLNESS Hypertension	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF CLERK J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	
19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JURY J. H. Harris		21. SIGNATURE OF JURY J. H. Harris	
22. SIGNATURE OF JURY J. H. Harris		23. SIGNATURE OF JURY J. H. Harris		24. SIGNATURE OF JURY J. H. Harris	
25. SIGNATURE OF JURY J. H. Harris		26. SIGNATURE OF JURY J. H. Harris		27. SIGNATURE OF JURY J. H. Harris	
28. SIGNATURE OF JURY J. H. Harris		29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JURY J. H. Harris	
31. SIGNATURE OF JURY J. H. Harris		32. SIGNATURE OF JURY J. H. Harris		33. SIGNATURE OF JURY J. H. Harris	
34. SIGNATURE OF JURY J. H. Harris		35. SIGNATURE OF JURY J. H. Harris		36. SIGNATURE OF JURY J. H. Harris	
37. SIGNATURE OF JURY J. H. Harris		38. SIGNATURE OF JURY J. H. Harris		39. SIGNATURE OF JURY J. H. Harris	
40. SIGNATURE OF JURY J. H. Harris		41. SIGNATURE OF JURY J. H. Harris		42. SIGNATURE OF JURY J. H. Harris	
43. SIGNATURE OF JURY J. H. Harris		44. SIGNATURE OF JURY J. H. Harris		45. SIGNATURE OF JURY J. H. Harris	
46. SIGNATURE OF JURY J. H. Harris		47. SIGNATURE OF JURY J. H. Harris		48. SIGNATURE OF JURY J. H. Harris	
49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JURY J. H. Harris		51. SIGNATURE OF JURY J. H. Harris	
52. SIGNATURE OF JURY J. H. Harris		53. SIGNATURE OF JURY J. H. Harris		54. SIGNATURE OF JURY J. H. Harris	
55. SIGNATURE OF JURY J. H. Harris		56. SIGNATURE OF JURY J. H. Harris		57. SIGNATURE OF JURY J. H. Harris	
58. SIGNATURE OF JURY J. H. Harris		59. SIGNATURE OF JURY J. H. Harris		60. SIGNATURE OF JURY J. H. Harris	
61. SIGNATURE OF JURY J. H. Harris		62. SIGNATURE OF JURY J. H. Harris		63. SIGNATURE OF JURY J. H. Harris	
64. SIGNATURE OF JURY J. H. Harris		65. SIGNATURE OF JURY J. H. Harris		66. SIGNATURE OF JURY J. H. Harris	
67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JURY J. H. Harris		69. SIGNATURE OF JURY J. H. Harris	
70. SIGNATURE OF JURY J. H. Harris		71. SIGNATURE OF JURY J. H. Harris		72. SIGNATURE OF JURY J. H. Harris	
73. SIGNATURE OF JURY J. H. Harris		74. SIGNATURE OF JURY J. H. Harris		75. SIGNATURE OF JURY J. H. Harris	
76. SIGNATURE OF JURY J. H. Harris		77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris		81. SIGNATURE OF JURY J. H. Harris	
82. SIGNATURE OF JURY J. H. Harris		83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
85. SIGNATURE OF JURY J. H. Harris		86. SIGNATURE OF JURY J. H. Harris		87. SIGNATURE OF JURY J. H. Harris	
88. SIGNATURE OF JURY J. H. Harris		89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris		93. SIGNATURE OF JURY J. H. Harris	
94. SIGNATURE OF JURY J. H. Harris		95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris		99. SIGNATURE OF JURY J. H. Harris	
100. SIGNATURE OF JURY J. H. Harris		101. SIGNATURE OF JURY J. H. Harris		102. SIGNATURE OF JURY J. H. Harris	

RECEIVED
FEB 5 1933
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

264

CERTIFICATE OF DEATH

Reg. Dist. No. 02580

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 25 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Pocomoke City				d. STREET ADDRESS 915 Clarke Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 Clarke Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NEVLIN Middle W. Last DRUMMOND				4. DATE OF DEATH Month February Day 12 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1912		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Corbin S. Drummond				14. MOTHER'S MAIDEN NAME Ceacy Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs J. W. Bailey, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, ENDOMETRIAL 172X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENOCARCINOMA, ENDOMETRIAL, UTERINE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 4 MONS.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-21 , 19 57 , to 2-12 , 19 58 , that I last saw the deceased alive on FEB 12 , 19 58 , and that death occurred at 5⁰⁰ P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) 212 MARKET ST. Pocomoke City, MD.		DATE SIGNED 2-13-58	
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-14-58		22c. NAME OF CEMETERY OR CREMATORY Salem M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson				24a. REC'D BY REGISTRAR FEB 18 '58		24b. REGISTRAR'S SIGNATURE W. Leach	

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 18 1932

RECEIVED

2607 CERTIFICATE OF DEATH

Reg. Dist. No.

02590

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirdditoe Rural #</u>		c. LENGTH OF STAY IN 1b <u>44 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirdditoe Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>R.</u> Last <u>Gashill</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27 - 1896</u>	
9. AGE (In years last birthday) <u>61/10/14</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Robbins, Pa. Worcester, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>William J. Robbins</u>			
14. MOTHER'S MAIDEN NAME <u>Fannie Coates</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. J. Carroll Gashill, Shirdditoe, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident, Vascular</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiac-renal disease</u> DUE TO (c) <u>4 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unclassified Primary Anemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u> </u> , to <u>2/11/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/10/58</u> , 19 <u> </u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Cohen</u>				ADDRESS (Street, city or town, state) <u>Snow Hill md</u>			
DATE SIGNED <u>2/11/58</u>				M.D.			
PHYSICIAN'S NAME (Type) <u>Walter Dennis Snow Hill, md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb 13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shirdditoe, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Dennis</u>				ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2698 CERTIFICATE OF DEATH

Reg. Dist. No. 02591

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route #1</u>		c. LENGTH OF STAY IN 1b <u>68 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>Snow Hill Route #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>W.</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12-1889</u>
9. AGE (In years last birthday) <u>68 3/4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>24</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Newark, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sidney W. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Clanor I. Mansford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clanor I. Stagg, Washington, D.C.</u>		Address <u>2619 Woodley Place N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertension</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-24-58</u> , 19 <u>58</u> , to <u>2-26-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-26-58</u> , 19 <u>58</u> , and that death occurred at <u>11:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Owen</u> M.D.		ADDRESS (Street, city or town, state) <u>2/27/58</u>	
PHYSICIAN'S NAME (Type) <u>Paul Owen</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Dunbar</u>		ADDRESS <u>Snow Hill, MD</u>	
24a. REC'D BY REGISTRAR <u>Feb 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2699 CERTIFICATE OF DEATH

Reg. Dist. No. 2592

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Washington</u>	
3. NAME OF DECEASED (Type or print) <u>Wilkins</u> First <u>Glenn</u> Middle <u>Kenly</u> Last		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 31, 1889</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRIC</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD G. KENLY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET GAMBELL PURNELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-32729</u>	
17. INFORMANT <u>Mrs. W. G. Kenly</u> Address <u>Berlin MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Acute Myocarditis</u> DUE TO <u>Interstitial Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>15 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Berlin</u> (County) <u>Worcester</u> (State) <u>md.</u>			
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>50</u> , to <u>2-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-28-58</u> , and that death occurred on <u>5:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford E. Schott M.D.</u> ADDRESS (Street, city or town, state) <u>Berlin Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Clifford E. Schott M.D. Berlin Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

DATE OF DEATH

PLACE

BUREAU V. 3

MAR 5 1958

RECEIVED

2610 CERTIFICATE OF DEATH

Reg. Dist. No. 02593

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY WORCESTER		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY WORCESTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				1d. STREET ADDRESS BAY ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIRGIE LEE McCABE				4. DATE OF DEATH Month FEB Day 17 Year 1958					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1904		9. AGE (In years last birthday) 53 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b. KIND OF BUSINESS OR INDUSTRY PRACTICAL		11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOSHUA McCABE				14. MOTHER'S MAIDEN NAME MARGARET ANNE TIMMONS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. CHARLES DINGES, BERLIN, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to Feb 17, 1958 , that I last saw the deceased alive on Feb 16, 1958 , and that death occurred at 2:30 AM , from the causes and on the date stated above.									
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Berlin, Md.				DATE SIGNED 2/19/58	
PHYSICIAN'S NAME (Type) Anna F. Burbage									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/19/58		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN MD			
23. FUNERAL DIRECTOR'S SIGNATURE Anna F. Burbage				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE FEB 21 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

State of Maryland

1. Name of Deceased: [illegible] 2. Sex: [illegible] 3. Age: [illegible] 4. Date of Birth: [illegible]

5. Place of Birth: [illegible]

6. Date of Death: [illegible] 7. Time of Death: [illegible]

8. Cause of Death: [illegible]

9. Signature of Physician: [illegible]

10. Signature of Registrar: [illegible]

11. Signature of Coroner: [illegible]

12. Signature of Medical Examiner: [illegible]

13. Signature of Burial Director: [illegible]

14. Signature of Minister: [illegible]

15. Signature of Undertaker: [illegible]

16. Signature of Funeral Home: [illegible]

17. Signature of Cemetery: [illegible]

18. Signature of Burial: [illegible]

19. Signature of Interment: [illegible]

20. Signature of Burial: [illegible]

21. Signature of Interment: [illegible]

22. Signature of Burial: [illegible]

23. Signature of Interment: [illegible]

24. Signature of Burial: [illegible]

25. Signature of Interment: [illegible]

26. Signature of Burial: [illegible]

27. Signature of Interment: [illegible]

28. Signature of Burial: [illegible]

BUREAU V. S.

FEB 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2611 CERTIFICATE OF DEATH

Reg. Dist. No.

02594

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. Randall Purnell</u>		4. DATE OF DEATH Month Day Year <u>Feb. 28 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 - 1897</u>
9. AGE (In years last birthday) <u>60 1/2</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. <u>60 1/2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self owned</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own car</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>William S. Purnell</u>		14. MOTHER'S MAIDEN NAME <u>Mara A. Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Howard Purnell</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis &</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>2/28/58</u> , that I last saw the deceased alive on <u>2/28/58</u> , 19 <u>58</u> , and that death occurred at <u>4:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Snow Hill, md</u> <u>3/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Paul</u>		M.D. <u>md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clay E. Hemm</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

1958

RECEIVED

2/28/28

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2612

CERTIFICATE OF DEATH

Reg. Dist. No. 02595

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MID</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>RICHARDSON</u> Last <u>RICHARDSON</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 14, 1873</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT YARD</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>NELLIE KELLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-16-96184</u>			
17. INFORMANT <u>Mrs. Edw. Richardson</u>				Address <u>Berlin, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Cerebro Vascular Accident</u> DUE TO <u>Anterio Sclerotic (CVI)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years.</u> (c) <u>10 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 13, 1958</u> to <u>Feb 18, 1958</u> , that I last saw the deceased alive on <u>Feb 19, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. J. Townsend Jr.</u> M.D.				ADDRESS (Street, city or town, State) <u>Ocean City, Md.</u> DATE SIGNED <u>Feb 19, 1958.</u>			
PHYSICIAN'S NAME (Type) <u>W. J. TOWNSEND JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

FEB 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2613

CERTIFICATE OF DEATH

02596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X. BERLIN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Eva Middle H. Last ROBBINS				4. DATE OF DEATH Month 1-EB Day 25 Year 1958			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 17, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMORY HENRY				14. MOTHER'S MAIDEN NAME LUCY MILLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address EDITH PRIDEAUX ATLANTIC CITY NJ			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Semibrit DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/15 , 19 58 , to 2/25 , 19 58 , that I last saw the deceased alive on 2/24 , 19 58 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Irony U. Sully, Jr. M.D.				ADDRESS (Street, city or town, state) Berlin Md		DATE SIGNED 3/1/58	
PHYSICIAN'S NAME (Type) Irony U. Sully, Jr. MD				Berlin Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/1/58		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burbage ADDRESS Berlin Md				24a. REC'D BY REGISTRAR DATE MAR 5 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2614

Reg. Dist. No. 02597

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Odell</u> Middle <u>Skeeter</u> Last <u>Skeeter</u>		4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE (In years last birthday) <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>NANCEMOND Co. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOHN C. SKEETER</u>		14. MOTHER'S MAIDEN NAME <u>SWEETIE SKEETER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-12-4354</u>	
17. INFORMANT <u>SWEETIE SKEETER</u>		Address <u>PORTSMOUTH VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>982x Stab wound of Chest</u> DUE TO (b) <u>involving the Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William H. Givens</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u>		22d. LOCATION (City, town, or county) (State) <u>NANCEMOND Co VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara A. Surban</u>		24a. REC'D BY REGISTRAR <u>FEB 6 '58</u>	
ADDRESS <u>Berlin Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Givens</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

BUREAU V. B.

1958 6 8

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2615

CERTIFICATE OF DEATH

Reg. Dist. No.

02598

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>	c. LENGTH OF STAY IN 1b <u>3 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. Snow Hill Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ina</u> Middle <u>J.</u> Last <u>Stevenson</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 - 1900</u>
9. AGE (In years last birthday) <u>57 1/2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Widdow, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Stevenson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marjorie Stevenson</u>		Address <u>Snow Hill, md Rural #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-vascular</u> <u>443X</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> (c) <u>1 yr 9 mos</u>			INTERNAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-8</u> , 19 <u>56</u> , to <u>2-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nory U. Sully, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type) <u>Nory U. Sully, Jr.</u>		DATE SIGNED <u>2/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Widdow Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Widdow, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Dummer</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>W. E. Dummer</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

BUREAU V. 3

FEB 19 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2616

Item 9 Film G225 2-10-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02599

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Anah</u> Middle <u>Sturgis</u> Last <u>Sturgis</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx. 71y</u>	
9. AGE (In years and birth day) <u>Unknown</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>			
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Leman Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT Address <u>Mr. Emma Smith, Snow Hill, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u>Atherosclerosis.</u> (c) <u>1 day</u> 10 yrs 18 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Mental Deterioration</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept</u> , 1955, to <u>Feb 3</u> , 1958, that I last saw the deceased alive on <u>Feb 1</u> , 1958, and that death occurred at <u>1600</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay Street</u> DATE SIGNED <u>2-4-58</u>							
ACTUAL SIGNATURE <u>Robert C. LaMar</u> M.D.				104 Bay Street			
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>				Snow Hill, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Morris</u> ADDRESS <u>Snow Hill, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>	

BUREAU V. 3

9 FEB

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2617 CERTIFICATE OF DEATH

Reg. Dist. No. 02600

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke City</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #3</u>				d. STREET ADDRESS <u>RFD #3</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MELLON</u> First <u>O.</u> Middle <u>TRADER</u> Last			4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>19 58</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Lloyd J. Cutten</u>				14. MOTHER'S MAIDEN NAME <u>Hattie G. Redden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs Travea M. Justice, Pocomoke City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Chronic Myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> , to <u>Feb 8, 1958</u> , that I last saw the deceased alive on <u>Feb 8, 1958</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. E. Critcher</u> M.D.				ADDRESS (Street, city or town, state) <u>New Church, Virginia</u> DATE SIGNED <u>Feb 13 1958</u>			
PHYSICIAN'S NAME (Type) <u>C. E. Critcher, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cutten Family Cemetery Rural Pocomoke City, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lenny St. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Redden</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2618 CERTIFICATE OF DEATH

Reg. Dist. No. **02601**

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. LENGTH OF STAY IN 1b 8 Mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X OCEAN CITY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. 7 D 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First POLLY Middle RAY Last TYNDALL				4. DATE OF DEATH Month FEB Day 16 Year 1958			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 4 1957	
9. AGE (In years last birthday) 8 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) SALISBURY MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ERNEST TYNDALL			
14. MOTHER'S MAIDEN NAME LOUISE MITCHELL				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. NO				17. INFORMANT MR. ERNEST TYNDALL Address OCEAN CITY MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bronchial 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 14, 1958 , to Feb 16, 1958 , that I last saw the deceased alive on Feb 15, 1958 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ocean City, MD DATE SIGNED Feb 18 1958 ACTUAL SIGNATURE F. J. Townsend, Sr. M.D. PHYSICIAN'S NAME (Type) F. J. Townsend, Sr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/18/58		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN Cem		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna H Burdge				ADDRESS Berlin Md		24a. REC'D BY REGISTRAR DATE FEB 21 1958	
24b. REGISTRAR'S SIGNATURE Quinn				24c. REGISTRAR'S SIGNATURE			

2082326 XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2619 CERTIFICATE OF DEATH

Reg. Dist. No.

02602

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u>				c. LENGTH OF STAY IN 1b <u>78 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural #2 Snow Hill</u>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Water</u> Last <u>Water</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31, 1879</u>	9. AGE (In years last birthday) <u>78 2/3</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>45</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>None</u>
13. FATHER'S NAME <u>John Water</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sturgis</u>			
15. YEARS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Hermine Blake</u>		Address <u>Snow Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPER TENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>15 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC CARDIAC FAILURE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, <u>19</u> Day, <u>19</u> Year			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Feb. 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>58</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. LaMar</u>				M.D. <u>104 Bay Street</u>		DATE SIGNED <u>2-4-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. LaMar, M.D.</u>				<u>Snow Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Holy</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman F. Wynn</u>				ADDRESS <u>Snow Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 6 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			

CERTIFICATE OF DEATH

THE STATE OF

DEPARTMENT OF HEALTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

ROBERT V. J.

FEB 6 1959

RECEIVED